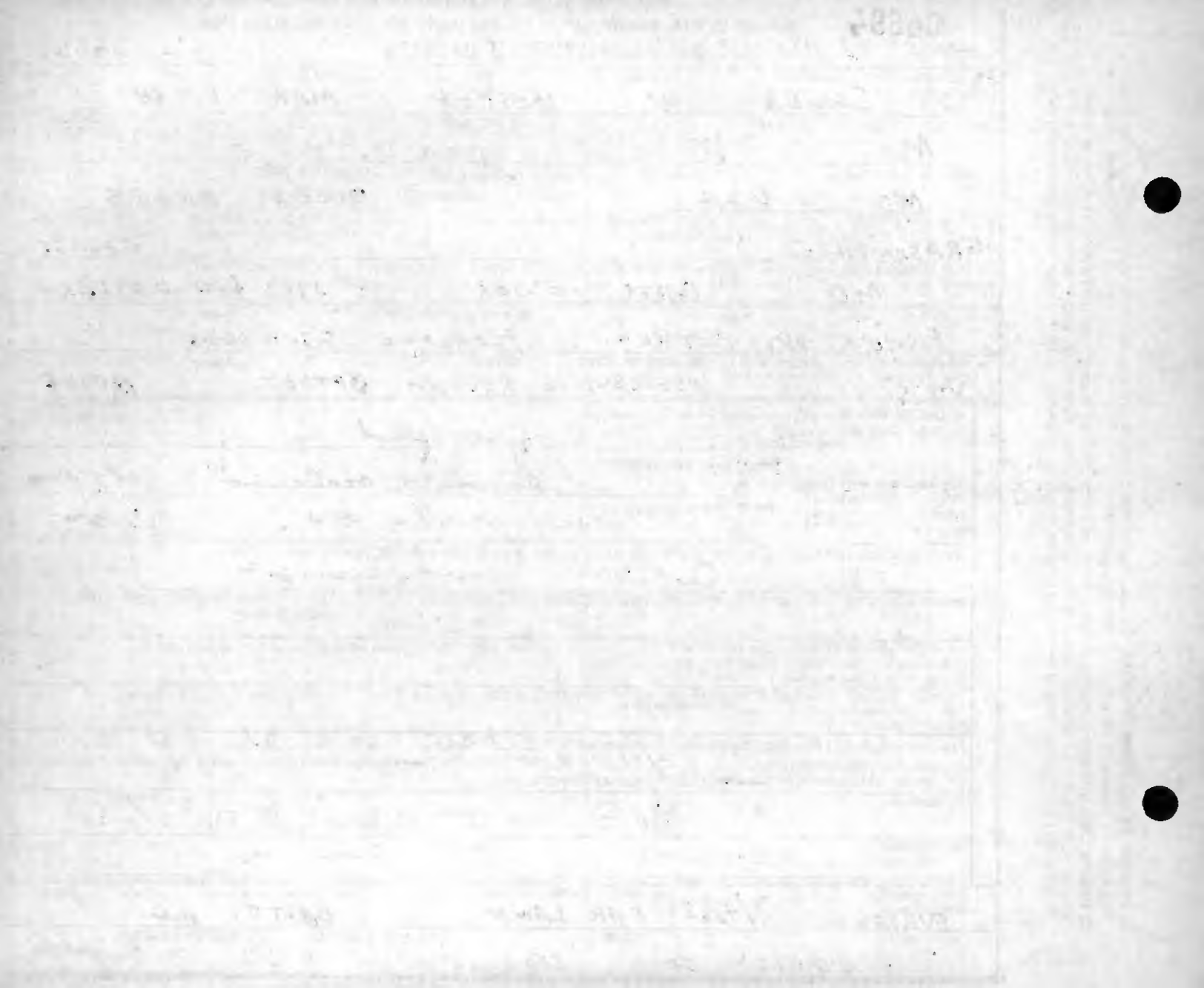


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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
Items 5 & 6 Film G398 3/8/68 kk												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <b>ELMER W. BETKEY</b>						2a. DATE OF DEATH Month Day Year <b>MAR 1 68</b>			2b. HOUR M			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>November 12, 1898</b>			6. AGE (in years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>QUEEN ANNES</b> Md.						
10. CITY OR TOWN OF DEATH <b>GRASONVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY <b>GARAGE</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>BALTO</b>			13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1413 OLD EASTERN</b>		
14. FATHER'S NAME First Middle Last <b>FRANK W. BETKEY</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>FLORENCE SAUNDERS</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>UNK</b>				16b. SOCIAL SECURITY NO. <b>086-28-9522</b>		17. INFORMANT Address <b>REGINA BETKEY ABOVE</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cordial arrest</b> <b>H109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pronounced occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>stroke vascular dis.</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>same day</b> <b>3 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201 Diabetes. partial amnesia</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <b>MAR 1, 1960</b> , to <b>3/1, 1968</b> , that (I) (we) last saw the deceased alive on <b>2/24 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>J. G. CONNELLY</b>						DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/2/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>J. G. CONNELLY</b>						22e. ADDRESS <b>300 MACE</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>						
24. FUNERAL DIRECTOR <b>J. G. CONNELLY SONS</b>						25a. REC'D BY REGISTRAR <b>MAR 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04695

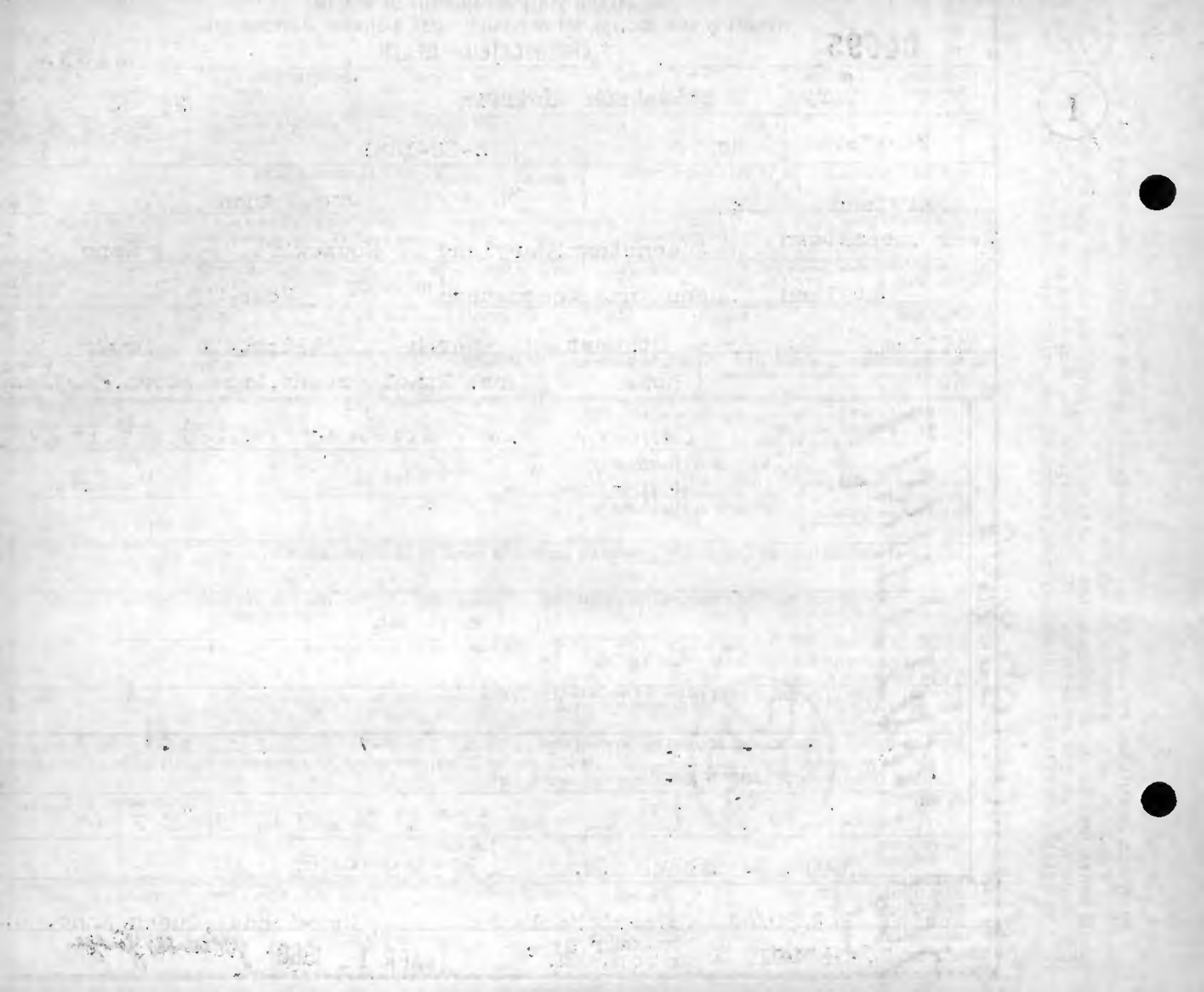
CERTIFICATE OF DEATH

04693

1. DECEASED-NAME (Type or print) <b>Mary Elizabeth Griffin</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>25</b> Year <b>68</b>			2b. HOUR <b>M</b>					
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>6-20-1881</b>		6. AGE (In years last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Queen Anne</b> Md.					
10. CITY OR TOWN OF DEATH <b>Near Queenstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Queenstown, Maryland</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Queen Anne</b>		13c. CITY OR TOWN <b>Queenstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>None</b>		
14. FATHER'S NAME First <b>William</b> Middle <b>James</b> Last <b>Stewart</b>			15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>Elizabeth</b> Last <b>Brown</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Ethel Greene, Queenstown, Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR ACCIDENT (STROKE)</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Remote</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-23-68</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>443x</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (his hospital) attended the deceased from <b>7-28</b> , 19 <b>67</b> , to <b>5-25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3-25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Ralph E. Libby</b>						DEGREE <b>MD.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3-28-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Ralph E. Libby, M.D.</b>						22e. ADDRESS <b>GRASONVILLE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>3/30/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carmichael</b>		23d. LOCATION (City or Town) (County) (State) <b>Carmichael, Queen Anne, Md.</b>				
24. FUNERAL DIRECTOR <b>Barbara L. Deshiell</b>						426 <b>Dover</b> Street Easton, Md.		25a. REC'D BY REGISTRAR <b>APR 1 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

28032

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VR 151 (4)  
30M REV 7/68

04696 Item 135 Film G398 3/15/68 kk				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04694			
1. DECEASED-NAME (Type or print) <b>Virginia Dare Matthews</b>				2a. DATE OF DEATH <b>Mar. 7, 1968</b>				2b. HOUR <b>3 P. M.</b>			
3. SEX <b>female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 28, 1876</b>		6. AGE (In years last birthday) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland Queen Anne</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Queen Anne</b> Md.					
10. CITY OR TOWN OF DEATH <b>nr. Crumpton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Walls Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Kent. Co.</b>		13c. CITY OR TOWN <b>Chestertown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>High St.</b>			
14. FATHER'S NAME First Middle Last <b>Wm. Matthews</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Silcox</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Jessie Powers - Chestertown, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary Bacterial Peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Septic</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4221</b>											
19a. DATE OF OPERATION <b>no</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>7:40 P.M. July 7, 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>no</b>		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>July 3, 1968</b> to <b>July 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>C. H. Metcalfe</b>				DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/7/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>C. H. Metcalfe</b>				22e. ADDRESS <b>Sudlersville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Chestertown, Md.</b>					
24. FUNERAL DIRECTOR <b>Walls Wells</b>				ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04697

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04695

1. DECEASED-NAME (Type or Print) <b>EMMA ELIZABETH ROBINSON</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <b>1968</b>			2b. HOUR <b>10 p.m.</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>JANUARY 22, 1898</b>		6. AGE (In years last birthday) <b>70</b> YRS.		7c. DATE PRONOUNCED DEAD Month <b>3</b> Day <b>23</b> Year <b>1968</b>			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>QUEEN ANNES</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Centreville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RURAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>DAY WORK</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>			13b. COUNTY <b>QUEEN ANNES</b>			13c. CITY OR TOWN <b>CENTREVILLE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>21452-2387</b>		
17. INFORMANT <b>DAUGHTER</b>			ADDRESS <b>Route #3 CENTREVILLE Md. 21617</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 years</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 mins.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>19</b> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John R. Smith, Jr.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>3/27/68</b>			
EXAMINER'S NAME (Type) <b>John R. Smith, Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county) <b>110 Broadway, Centreville</b>											
23a. BURIAL-CREMATATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>MARCH 27, 1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>ROSEVILLE CEMETERY</b>			
23d. LOCATION (City or Town) <b>Church Hill</b> (County) <b>QUEEN ANNES</b> (State) <b>Md.</b>				23e. REC'D BY REGISTRAR <b>APR 1 - 1968</b>				23f. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			
24. FUNERAL DIRECTOR <b>James H. B...</b>				ADDRESS <b>Centreville, Md.</b>							





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04696  
02693  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>xxx</u>		d. STREET ADDRESS <u>xxx</u>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> <u>Carl</u> <u>Smith Jr.</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1954</u>
9. AGE (in years just birthday) <u>13</u> yrs.		IF UNDER 1 YEAR: Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Smith</u>		14. MOTHER'S MAIDEN NAME <u>Gladys Mansfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>xxx</u>	
17. INFORMANT <u>Edward Smith--Grasonville, Md.</u>		Address <u>xxx</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> 743.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <u>Cardiomegaly, Cardiac, pulmonary defect</u> DUE TO (c) <u>Congenital heart abnormality (Birth Defect)</u> 753.1		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>13 yrs</u> (Birth Defect) <u>13 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 1, 1967</u> to <u>Mar 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>Mar 3, 1968</u> , and that death occurred at <u>Mar 3, 1968</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. R. Smith Jr.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John R. Smith, Jr.</u>		22d. ADDRESS <u>Centreville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 6</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		23d. LOCATION (City, town or county) (State) <u>Centreville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	

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7